can be made when the service was emergency in nature or when it is determined reasonable and would have been approved if preauthorization had been requested. (7-15-87)

01. Scope of Coverage and General Requirements. (7-1-93)

a. The Department will reimburse for necessary transportation to and from providers of Medicaid approved medical services for a Medicaid recipient. Out-of-state transportation will not be reimbursed without obtaining authorizations required in Subsection 015.03. (2-15-93)

i. The Department or its designee may authorize the cost of an attendant or one (1) immediate family member to accompany the recipient, if necessary, and the cost of the attendant's immediate family member's transportation, meals, lodging, and salary for the attendant, if he is not a member of the recipient's family. The Department will not pay room and board costs for an attendant once the recipient being escorted is admitted to an inpatient facility. The Department will pay room and board costs to one (1) immediate family member while the recipient is inpatient in a facility. (5-4-94)

ii. For any out-of-state requests for transportation costs, the Department or its designee will only authorize transportation costs to the nearest available medical facility. (2-15-93)

b. If private car transportation is used, the Department must authorize payment for such transportation at rates established by the Department. The private carrier is responsible to provide all necessary insurance at no cost to the Department. (2-15-93)

c. If other than private transportation is used, the transportation must be the least expensive yet the most appropriate form available. (11-10-81)

d. Reimbursement is to be made by the Department for necessary transportation to any person, including but not limited to the recipient, or a relative or friend of the recipient. (1-16-80)

e. Preauthorization of transportation for a MA recipient to consult with or be treated by a provider of medical care at a distant point, either in or out-of-state, is required. For purposes of these rules, a "distant point" is defined as more than ten (10) miles from the recipient's residence. The Department or its designee must determine the following: (2-15-93)

i. That adequate and comparable medical services are not available locally. When the services are available locally and/or more than one service provider is within the local area, the Department's reimbursement is limited to round trip mileage to the closest provider of the necessary service; and (2-15-93)

ii. That an appointment has been made with a provider at the distant point; and (11-10-81)

iii. If applicable, that a referral has been made by the patient's attending physician; and (1-16-80)

iv. When lodging is required, the Department or its designee will preauthorize it insuring that the least expensive yet most appropriate lodging is provided. Receipts for lodging must be attached to the appropriate claim form submitted to the Department. (2-15-93)

v. Transportation will not be authorized unless out-of-state care authorizations have been obtained as required in Subsection 015.03. Exceptions to this requirement are: Veteran's Hospitals and specialty hospitals which do not make a charge to the general public. Therefore, no authorization for hospitalization is made by Medicaid. (2-15-93)

vi. The Department or its designee will not authorize transportation and/or lodging when other sources are available at minimal or no cost such as Red Cross, Easter Seal Society, Cancer Society, fraternal and church organizations, Ronald McDonald Houses, and other private or social agencies which provide transportation and/or lodging. (2-15-93)

f. The Department will only authorize meals when overnight travel to a distant point is required and cooking facilities are not available at a reasonable cost. The actual cost of the meals will be authorized up to the amount allowed by the State Board of Examiners for state employees. (2-15-93)

02. Ambulance Service. Ambulance service is reimbursable in emergency situations or when prior authorization has been obtained from the Field Office. Payment for ambulance services is subject to the following limitations: (11-10-81)

a. If a MA recipient is also a Medicare recipient, a provider must first bill Medicare for services rendered; and (11-10-81)

b. If Medicare does not pay the entire bill for ambulance service, the provider is to secure an "Explanation of Benefits" (EOB) from Medicare, attach it to the appropriate claim form and submit it to the Department; and (11-10-81)

c. For Medicare recipients, the Department will reimburse providers for deductible and co-insurance not to exceed the usual and customary fees; and (11-10-81)

d. The Department's payment for ambulance services is not to exceed usual and customary charges as determined by Medicare; and (11-10-81)

e. Before payment is made by the Department, a MA recipient must utilize any available insurance benefits to pay for ambulance services. (11-10-81)

f. If an emergency does not exist, prior written authorization to use ambulance services must be secured from the Field Office. (11-10-81)

g. Each billing invoice for ambulance service must have prior authorization attached, if appropriate, and be submitted to the Department for payment. (11-10-81)

h. Ambulance service must be medically necessary and reasonable in order to be covered by MA. Medical necessity is established when the recipient's condition is such that use of any other method of transportation would endanger his life. (11-10-81)

03. Destination. Only local transportation by ambulance is covered. In exceptional situations where the ambulance transportation originates beyond the locality to which the recipient was transported, full payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities. (11-10-81)

04. Air Ambulance Service. In some areas, transportation by airplane may qualify as ambulance services. Air ambulance services are covered only when: (11-10-81)

a. The point of pickup is inaccessible by land vehicle; or (11-10-81)

b. Great distances or other obstacles are involved in getting the recipient to the nearest appropriate facility and speedy admission is essential; and (11-10-81)

01. In General. Each Field Office staff person is to be alert to the health needs of recipients as a part of the provision of social services. (11-10-81)

02. Information. (7-1-93)

a. Recipients must be informed by the Field Office of the amount, scope, and duration of medical care and services available through MA, and the steps necessary to secure the services. (11-10-81)

b. Medical consultation is available to the Field Office on behalf of a MA recipient through the Bureau. (11-10-81)

c. Informational and training brochures are available to the Field Office through the Bureau concerning medical problems, diagnosis and treatment, the implications of serious disabilities and illnesses, and the social services available to families and persons suffering from serious illnesses or disabilities. (11-10-81)

156. -- 159. (RESERVED).

160. LONG-TERM CARE. (1-16-80)

01. Care and Services Provided. (1-16-80)

a. Nursing Facility Care. The minimum content of care and services for nursing facility patients must include the following (see also 180.04): (7-1-94)

i. Room and board; and (1-16-80)

ii. Bed and bathroom linens; and (1-16-80)

iii. Nursing care, including special feeding if needed; and (1-16-80)

iv. Personal services; and (1-16-80)

v. Supervision as required by the nature of the patient's illness; and (1-16-80)

vi. Special diets as prescribed by a patient's physician; and (1-16-80)

vii. All common medicine chest supplies which do not require a physician's prescription including but not limited to mouthwashes, analgesics, laxatives, emollients, burn ointments, first aid cream, protective creams and liquids, cough and cold preparations, and simple eye preparations; and (1-16-80)

viii. Dressings; and (1-16-80)

ix. Administration of intravenous, subcutaneous, and/or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; and (1-16-80)

x. Application or administration of all drugs; and (1-16-80)

xi. All medical supplies including but not limited to gauzes, bandages, tapes, compresses, cottons, sponges, hot water bags, ice bags, disposable syringes, thermometers, cellucotton or any other type of pads used to save labor or linen, and rubber gloves; and (1-16-80)

xii. Social and recreational activities; and (1-16-80)

xiii. Items which are utilized by individual patients but which are reuseable and expected to be available, such as bed rails, canes, crutches, walkers, wheel chairs, traction equipment, and other durable medical equipment. (11-10-81)

(7-1-94)

b. Intermediate Care-Mentally Retarded. The minimum content of care and services for ICF/MR must include the services identified in Subsection 160.01.a. and Manual Subsection 180.08, and social and recreational activities. (7-1-94)

c. Direct Care Staff. Direct Care staff in an ICF/MR are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Direct care staff in an ICF/MR include those employees whose primary duties include the provision of hands-on, face-to-face contact with the clients of the facility. This includes both regular and live-in/sleep-over staff. It excludes professionals such as psychologists, nurses, and others whose primary job duties are not the provision of direct care, as well as managers/ supervisors who are responsible for the supervision of staff. (5-25-93)

d. Level of Involvement. Level of involvement relates to the severity of an MA recipients mental retardation. Those levels, in decreasing level of severity, are: profound, severe, moderate, and mild. (5-25-93)

e. Direct Care Staffing Levels. The reasonable level of direct care staffing provided to an MA recipient in an ICF/MR setting will be dependent upon the level of involvement and the need for services and supports of the recipient as determined by the Department, or its representative, and will be subject to the following constraints: (7-1-94)

i. Direct care staffing for a severely and profoundly retarded recipient residing in an ICF/MR must be a maximum of 68.25 hours per week. (5-25-93)

ii. Direct care staffing for a moderately retarded recipient residing in an ICF/MR must be limited to a maximum of 54.6 hours per week. (5-25-93)

iii. Direct care staffing for a mildly retarded recipient residing in an ICF/MR must be limited to a maximum of 34.125 hours per week. (5-25-93)

f. The annual sum total level of allowable direct care staff hours for each residential living unit will be determined in the aggregate as the sum total of the level of staffing allowable for each resident residing in that residential living unit as determined in Subsection 160.01.e. (5-25-93)

g. Phase-in Period. If enactment of Subsection 160.01.e. requires a facility to reduce its level of direct care staffing, a six month phase in period will be allowed from the date of the enactment of this section, without any resulting disallowances. Should disallowances result, the hourly rate of direct care staff used in determining disallowances will be the weighted average of the hourly rates paid to a facility's direct care staff, plus the associated benefits, at the end of the phase-in period. (5-25-93)

h. Exceptions. Should a provider be able to show convincing evidence documenting that the annual aggregate direct care hours as allowed under this section will compromise their ability to supply adequate care to the clients, as required by federal regulations and state rules, within an ICF/MR residential living unit and that other less costly options would not alleviate the situation, the Department will approve an additional amount of direct care hours sufficient to meet the extraordinary needs. (5-25-93)

02. Conditions of Payment. (2-25-93)

a. As a condition of payment by the Department for long-term care on behalf of MA recipients, each fully licensed long-term care facility is to be under the supervision of an administrator who is currently licensed under the laws of the state of Idaho and in accordance with the rules of the Bureau of Occupational Licenses. (5-25-93)

b. Nursing facilities and ICF/MR facilities will be reimbursed in accordance with Idaho Department of Health and Welfare Rules, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho." (5-25-93)

03. Post-eligibility Treatment of Income. Where an individual is determined eligible for MA participation in the cost of his long term care, the Department must reduce its payment to the long term care facility by the amount of his income considered available to meet the cost of his care. This determination is made in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.03.05.585, "Rules Governing Eligibility for Aid for Families with Dependent Children (AFDC)." (5-25-93)

a. The amount which the MA recipient receives from SSA as reimbursement for his payment of the premium for Part B of Title XVIII (Medicare) is not considered income for patient liability (see Subsection 165.02. and Idaho Department of Health and Welfare Rules Title 3, Chapter 5, Subsection 522.02.c., "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)." (5-25-93)

b. Payment by the Department for the cost of long term care is to include the date of the recipient's discharge only if the discharge occurred after 3 p.m. If a Medicaid patient dies in a nursing home, his date of death is covered regardless of the time of occurrence. If an admission and a discharge occur on the same date, then one (1) day of care shall be deemed to exist. (11-1-86)

04. Payments for Periods of Temporary Absence. Payments may be made for reserving beds in long-term care facilities for recipients during their temporary absence if the facility charges private paying patients for reserve bed days, subject to the following limitations: (10-22-93)

a. Facility Occupancy Limits. Payment for periods of temporary absence from long term care facilities will not be made when the number of unoccupied beds in the facility on the day preceding the period of temporary absence in question is equal to or greater than the larger of: (4-6-83)

i. Five (5) beds; or (4-6-83)

ii. Five percent (5%) of the total number of licensed beds in the facility. (4-6-83)

b. Time Limits. Payments for periods of temporary absence from long term care facilities will be made for: (4-6-83)

i. Therapeutic home visits for other than ICF/MR residents of up to three (3) days per visit and not to exceed a total of fifteen (15) days in any consecutive twelve (12) month period so long as the days are part of a treatment plan ordered by the attending physician. (12-22-88)

ii. Therapeutic home visits for ICF/MR residents of up to thirty-six (36) days in any consecutive twelve (12) month period so long as the days are part of a written treatment plan ordered by the attending physician. Prior approval from the RMU must be obtained for any home visits exceeding fourteen (14) consecutive days. (10-22-93)

c. Limits on Amount of Payments. Payment for reserve bed days will be the lesser of the following: (4-6-83)

i. Seventy-five percent (75%) of the audited allowable costs of the facility unless the facility serves only ICF/MR residents, in which case the payment will be one hundred percent (100%) of the audited allowable costs of the facility; or (12-22-88)

ii. The rate charged to private paying patients for reserve bed days. (4-6-83)

05. Payment Procedures. Each long term care facility must submit its claims to the Department in accordance with the procedures established by the Department. The Department will not pay for a claim in behalf of a MA recipient unless the information on the claim is consistent with the information in the Department's computer eligibility file. (11-10-81)

06. Long-Term Care Facility Responsibilities. In addition to the responsibilities set forth in Idaho Department of Health and Welfare Rules, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho," each long term care facility administrator, or his authorized representative, must report: (7-1-94)

a. The following information to the appropriate Field Office within three (3) working days of the date the facility has knowledge of: (7-13-89)

i. Any readmission or discharge of a recipient, and any temporary absence of a recipient due to hospitalization or therapeutic home visit; and (7-13-89)

ii. Any changes in the amount of a recipient's income; and (1-16-80)

iii. When a recipient's account has exceeded one thousand four hundred dollars ($1,400) for a single individual or two thousand one hundred fifty dollars ($2,150) for a married couple; and (11-10-81)

iv. Other information about a recipient's finances which potentially may affect eligibility for MA. (11-10-81)

b. PASARR. All medicaid certified nursing facilities must participate in, cooperate with, and meet all requirements imposed by the Preadmission Screening and Annual Resident Review program (hereafter "PASARR") as set forth in 42 C.F.R., Part 483, Subpart C, which, pursuant to Idaho Code, 67-5229, is incorporated by reference herein. (11-6-93)

i. Background and Purpose. The purpose of these provisions is to comply with and implement the PASARR requirements imposed on the state by federal law. The purpose of those requirements is to prevent the placement of individuals with mental illness (MI) or mental retardation (MR) in a nursing facility (NF) unless their medical needs clearly indicate that they require the level of care provided by a nursing facility. This is accomplished by both pre-admission screening (PAS) and annual resident review (ARR). Individuals for whom it appears that a diagnosis of MI or MR is likely are identified for further screening by means of a Level I screen. The actual PASARR is accomplished through a Level II screen where it is determined whether, because of the individual's physical and mental condition, he or she requires the level of services provided by an NF. If the individual with MI or MR is determined to require an NF level of care, it must also be determined whether the individual requires specialized services. PASARR applies to all individuals entering or residing in an NF, regardless of payment source. (11-6-93)

ii. Policy. It is the policy of the Department that the difficulty in providing specialized services in the NF setting makes it generally inappropriate to place individuals needing specialized services in an NF. This policy is supported by the background and development of the federal PASARR requirements, including the narrow definition of MI adopted by federal law. While recognizing that there are exceptions, it is envisioned that most indi-

viduals appropriate for NF placement will not require services in excess of those required to be provided by NFs by 42 C.F.R. 483.45. (11-6-93)

iii. Inter-agency agreement. The state Medicaid agency will enter into a written agreement with the state mental health and mental retardation authorities as required in 42 C.F.R. 431.621(c). This agreement will, among other things, set forth respective duties and delegation of responsibilities, and any supplemental criteria to be used in making determinations.

(a) The "State mental health authority" (hereafter "SMHA") is the Division of Family and Community Services of the Department, or its successor entity. (11-1-93)

(b) The "State mental retardation or developmental disabilities authority" (hereafter "SDDA") is the Division of Family and Community Services of the Department, or its successor entity. (11-6-93)

iv. Coordination. The PASARR process is a coordinated effort between the state Medicaid agency, the SMHA and SDDA, independent evaluators and NFs. PASARR activities, to the extent possible, will be coordinated through the Regional Medicaid Units (RMUs). RMUs will also be responsible for record retention and tracking functions. However, NFs are responsible for assuring that all screens are obtained and for coordination with the RMU, independent MI evaluators, the SMHA and SDDA, and their designees. Guidelines and procedures on how to comply with these requirements can be found in "Statewide PASARR Procedures," a reference guide. (11-6-93)

(a) Level I Screens. All required level I reviews must be completed and submitted to the RMU, prior to admission to the facility.

(b) Level II Screens. When a NF identifies an individual with MI and/or MR through a level I screen, or otherwise, the NF is responsible for contacting the SMHA or SDDA (as appropriate), or its designee, and assuring that a level II screen is completed prior to admission to the facility, or in the case of an existing resident, completed in order to continue residing in the facility. (11-6-93)

(c) Annual Resident Reviews (ARR). Those individuals identified with MI and/or MR must be reviewed annually as a condition of continued stay in the facility. (11-6-93)

v. Determinations. Determinations as to the need for NF care and determinations as to the need for specialized services should not be made independently. Such determinations must often be made on an individual basis, taking into account the condition of the resident and capability of the facility to which admission is proposed to furnish the care needed. When an individual identified with MI and MR is admitted to a NF, the NF is responsible for meeting that individual's needs, except for the provision of specialized services. (7-1-94)

(a) Level of care. (11-6-93)

(1) Individual determinations. Must be based on evaluations and data as required by these rules. (11-6-93)

(2) Catagorical determinations. Recognizing that individual determinations of level of care are not always necessary, those catagories set forth as examples at 42 C.F.R. 483.130(d) are hereby adopted as appropriate for catagorical determinations. When NF level of care is determined appropriate categorically, the individual may be conditionally admitted prior to completion of the determination for specialized services. However, conditional admissions cannot exceed seven (7) days, except for respite admissions, which cannot exceed thirty (30) consecutive days in one (1) calendar year. (11-6-93)

(b) Specialized services. Specialized services for mental illness as defined in 42 C.F.R. 483.120(a)(1), and for mental retardation as defined in 42 C.F.R. 483.120(a)(2), are those services provided by the state which due to the intensity and scope can only be delivered by personnel and programs which are not included in the specialized rehabilitation services required of nursing facilities under 42 C.F.R. 483.45. The need for specialized services must be documented and included in both the resident assessment instrument and the plan of care. (11-6-93)

(1) Individual determinations. Must be based on evaluations and data as required by these rules. (11-6-93)

(2) Group determinations. Catagorical determinations that specialized services are not needed may be made in those situations permitted by 42 C.F.R. 483.130. The same time limits, imposed by Subsection 160.06.b.v.(a)(2) shall apply. (11-6-93)

vi. Penalty for non-compliance. No payment shall be made for any services rendered by a NF prior to completion of the level I screen and, if required, the level II screen. Failure to comply with PASARR requirements for all individuals admitted or seeking admission may also subject a NF to other penalties as part of certification action under 42 CFR 483.20. (11-6-93)

vii. Appeals. Discharges, transfers, and preadmission screening and annual resident review (PASARR) determinations may be appealed to the extent required by 42 C.F.R., Part 483, Subpart E, which, pursuant to Idaho Code, 67-5229, is incorporated by reference herein. Appeals under this paragraph shall be made in accordance with the fair hearing provisions of the Idaho Department of Health and Welfare, "Rules Governing Contested Case Proceedings and Declaratory Rulings" IDAPA 16, TITLE 05, Chapter 03, Section 300. A level I finding of MI or MR is not an appealable determination. It may be disputed as part of a level II determination appeal. (11-6-93)

viii. Automatic repeal. In the event that the Preadmission Screening and Annual Resident Review program is eliminated or made non-mandatory by act of congress, the provisions of Subsection 160.06.b. of this chapter shall cease to be operative on the effective date of any such act, without further action. (11-6-93)

07. Provider Application and Certification. (1-16-80)

a. A facility can apply to participate as a nursing facility. (7-1-94)

b. A facility can apply to participate as an ICF/MR facility. (1-16-80)

08. Licensure and Certification. (7-13-89)

a. Upon receipt of an application from a facility, the Licensing and Certification Agency must conduct a survey to determine the facility's compliance with certification standards for the type of care the facility proposes to provide to MA recipients. (7-13-89)

b. If a facility proposes to participate as a skilled nursing facility, Medicare (Title XVIII) certification and program participation is required before the facility can be certified for Medicaid. The Licensing and Certification Agency must determine the facility's compliance with Medicare requirements and recommend certification to the Medicare Agency. (7-1-94)

c. If the Licensing and Certification Agency determines that a facility meets Title XIX certification standards for nursing facility care or ICF/MR, the Section must certify to the appropriate branch of government that the facility meets the standards for NF or ICF/MR types of care. (7-1-94)

d. Upon receipt of the certification from the Licensing and Certification Agency, the Bureau may enter into a provider agreement with the long term care facility. (7-13-89)

e. After the provider agreement has been executed by the Facility Administrator and by the Chief of the Bureau, one (1) copy must be sent by certified mail to the facility and the original is to be retained by the Bureau. (11-10-81)

09. Determination of Entitlement to Long-Term Care. Entitlement to MA participation in the cost of long-term care exists when the individual is eligible for MA and the RNR has determined that the individual meets the criteria for NF or ICF/MR care and services. Entitlement must be determined prior to authorization of payment for such care for an individual who is either a recipient of or an applicant for MA. (7-1-94)

a. The criteria for determining a MA recipient's need for either nursing facility care or intermediate care for the mentally retarded must be as set forth in Manual Subsections 180.03 or 180.08. In addition, the IOC/UC nurse must determine whether a MA recipient's needs could be met by noninpatient alternatives including, but not limited to, remaining in an independent living arrangement or residing in a room and board situation. (7-1-94)

b. The recipient can select any certified facility to provide the care required. (11-10-81)

c. The final decision as to the level of care required by a MA recipient must be made by the IOC/UC Nurse. (7-1-94)

d. The final decision as to the need for DD or MI active treatment must be made by the appropriate Department staff as a result of the Level II screening process. (7-13-89)

e. No payment must be made by the Department on behalf of any eligible MA recipient to any long-term care facility which, in the judgment of the IOCT/UCT is admitting individuals for care or services which are beyond the facility's licensed level of care or capability. (7-1-94)

10. Authorization of Long-Term Care Payment. If it has been determined that a person eligible for MA is entitled to MA participation in the cost of long-term care, and that the facility selected by the recipient is licensed and certified to provide the level of care the recipient requires, the Field Office will forward to such facility an "authorization for Long-Term Care Payment" form HW 0459. (7-1-94)

161. HOSPITAL SWING-BED REIMBURSEMENT. The Department will pay for NF care in certain rural hospitals. Following approval by the Department, such hospitals may provide service to recipients who require NF level of care as defined by Manual Subsection 180.03 in licensed hospital ("swing") beds. (7-1-94)

01. Facility Requirements. The Department will approve hospitals for NF care provided to eligible recipients under the following conditions: (7-1-94)

a. The Department's Licensure and Certification Section finds the hospital in conformance with the requirements of 42 CFR 482.66 "Special Requirements" for hospital providers of long-term care services ("swing-beds"); and (8-23-90)

b. The hospital is approved by the Medicare program for the provision of "swing-bed" services; and (5-1-84)

c. The facility does not have a twenty-four (24) hour nursing waiver granted under 42 CFR 488.54(c); and (8-23-90)

d. The hospital must not have had a swing-bed approval terminated within the two (2) years previous to application for swing-bed participation; and (8-23-90)

e. The hospital must be licensed for less than one hundred (100) beds as defined by 42 CFR 482.66(a)(1) for swing-bed purposes; and (8-23-90)

f. NF services in swing-beds must be rendered in beds used interchangeably to furnish hospital or NF type services. (7-1-94)

02. Recipient Requirements. The Department will reimburse hospitals for recipients under the following conditions: (5-1-84)

a. The recipient is determined to be entitled to such services in accordance with Subsection 080.01; and (7-1-94)

b. The recipient is authorized for payment in accordance with Subsection 160.10.; and (12-31-91)

03. Reimbursement for "Swing-Bed" Patient Days. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (8-23-90)

a. Payment rates for routine NF services will be at the weighted average Medicaid rate per patient day paid to hospital based NF/ICF facilities for routine services furnished during the previous calendar year. ICF/MR facilities' rates are excluded from the calculations. (7-1-94)

b. The rate will be calculated by the Department by March 15th of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. (8-23-90)

c. The weighted average rate for NF swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. (7-1-94)

d. Routine services as addressed in Subsections 160.01.a include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in Idaho Department of Health and Welfare Rules, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho." (7-1-94)

e. The Department will pay the lessor of the established rate, the facility's charge, or the facility's charge to private pay patients for "swing-bed" services. (8-23-90)

f. Reimbursement of ancillary services not included in the nursing facility rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 126. (7-1-94)

g. The number of swing-bed days that may be reimbursed to a provider in a twelve (12) month period will be limited to the greater of one thousand ninety five (1,095) days which may be prorated over a shorter fiscal period or fifteen percent (15%) of the product of the average number of available licensed beds in the hospital in the period and the number of days in the fiscal period. (8-23-90)